# 1AC

### 1AC - Framing

**The meta ethic should be moral pluralism. Prefer-**

#### [1] Empirics- Best studies prove pluralistic tendencies are inevitable

Polzler and Wright 19[Thomas Pölzler and Jennifer Cole Wright- “Empirical research on folk moral objectivism” <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6686698/> NCBI. Published July 5th 2019]

Examining these studies' results more closely, however, makes it less clear whether this interpretation is appropriate (Pölzler, 2018b). Take again Goodwin and Darley's study. In this study, almost 30% of subjects' responses to the disagreement measure and almost 50% of their responses to the truth‐aptness measure fell on the option that the researchers took to be indicative of subjectivism (Goodwin & Darley, 2008, pp. 1347, 1351). Moreover, while some moral statements were dominantly classified as objective (e.g., the above statement about robbery), many others were dominantly classified as nonobjective (e.g., the stem cell research statement). This suggests that subjects in Goodwin and Darley's study may have actually favored what Wright, Grandjean, and McWhite (2013) called “metaethical pluralism,” i.e., they sometimes sided with objectivism and other times with nonobjectivism. More recent studies have by and large confirmed this hypothesis of folk metaethical pluralism. Wright et al. (2013) and Wright, McWhite, and Grandjean (2014), for example, replicated Goodwin and Darley's results, using the exact same measures, but letting subjects classify the presented statements as moral and nonmoral themselves. Objectivity ratings for statements that were dominantly self‐classified as moral varied between as little as 5% and as much as 85%. Research based on different measures yielded high proportions of intrapersonal variation as well (e.g., Beebe, 2014; Beebe, Qiaoan, Wysocki, & Endara, 2015; Beebe & Sackris, 2016; Fisher, Knobe, Strickland, & Keil, 2017; Goodwin & Darley, 2012; Heiphetz & Young, 2017; Wright, 2018; Zijlstra, forthcoming‐a).2

#### Thus, the standard is promoting pragmatic deliberation. Prefer-

#### [1] TJFS- Frameworks should be fair/educational like any other argument. A] Inclusion – Agonism definitionally is a procedural for allowing almost any argumentation in the debate space which controls the internal link to inclusion which is an impact multiplier B] Resource Disparities- Discursive frameworks ensure big squads don’t have a comparative advantage since debates become about quality of arguments rather than quantity and require a higher level of analytic thinking that small schools have.

#### [2] Value Pluralism- Other ethical theories rely on minimalistic criteria as their foundation, our framework resolves this by using these criteria to better inform our judgments LaFollete 2K "Pragmatic Ethics" [Hugh LaFollette](http://www.hughlafollette.com/index.htm) In [Blackwell Guide to Ethical Theory](http://www.hughlafollette.com/papers/b-guide.htm) 2000. Hugh LaFollette is Marie E. and Leslie Cole Professor in Ethics at the University of South Florida St. Petersburg. He is editor-in-chief of The International Encyclopedia of Ethics. Bracketed for grammer

Employs criteria, but is not criterial The previous discussions enable us to say more precisely why pragmatists reject a criterial view of morality. Pragmatism's core contention that **practice** is primary in philosophy **rules out** the hope of logically prior **criteria**. Any meaningful criteria evolve from our attempt to live morally – in deciding what is the best action in the circumstances. **Criteria** are not discovered by pure reason, and they **are not fixed**. As ends of action, they are always revisable. **As we obtain new evidence** about ourselves and our world, and as our worlds changes, **we find** that **what was appropriate** for the old environment **may not be conducive to** survival in **the new [world]** one. A style of teaching that might have been ideal for one kind institution (a progressive liberal arts college) at one time (the 60s) may be wholly ineffective in another institution (a regional state university) at another time (the 80s). But that is exactly what we would expect of an evolutionary ethic. Neither could criteria be complete. **The moral world is complex and changeable. No** set of **criteria could give us univocal answers about how we should behave in all circumstances.** If we cannot develop an algorithm for winning at chess, where there are only eighteen first moves, there is no way to develop an algorithm for living, which has a finitely large number of "first moves." Moreover, while the chess environment (the rules) stays constant, our natural and moral environments do not. We must adapt or fail. While there is always one end of chess -- the game ends when one player wins – the ends of life change as we grow, and **as** our **environments change**. Finally, we cannot resolve practical moral questions simply by applying criteria. We do not make personal or profession decisions by applying fixed, complete criteria. Why should we assume we should make moral decisions that way? Appropriates insights from other ethical theories Nonetheless, there is a perfectly good sense in which a pragmatic ethic employs what we might call criteria, but their nature and role dramatically differ from that in a criterial morality (Dewey 1985/1932) . **Pragmatic criteria** are not external rules we apply, but **are tools we use in making informed judgements**. They embody learning from previous action, they express our tentative efforts to isolate morally relevant features of those actions. These **emergent criteria can become integrated into our habits,** thereby **informing** the **ways** that **we react to**, think about, and imagine **our worlds** and our relations to others. This explains why pragmatists think other theories can provide guidance on how to live morally. Standard moral theories err not because they offer silly moral advice, but because they misunderstand that advice. **Other** moral **theories can** help us **isolate** (and habitually focus on) **morally relevant features** of action. And pragmatists take help wherever they can get it. Utilitarianism does not provide an algorithm for deciding how to act, but it shapes habits to help us "naturally" attend to the ways that our actions impact others. Deontology does not provide a list of general rules to follow, but it sensitizes us to ways our actions might promote or undermine respect for others. Contractarianism does not resolve all moral issues, but it sensitizes us to the need for broad consensus. That is why it is mistaken to suppose that the pragmatist makes specific moral judgements oblivious to rules, principles, virtues, and the collective wisdom of human experience. **The pragmatist absorbs these insights** into her habits, **and** thereby **shapes how she habitually responds,** and how she habitually deliberates when deliberation is required. This also explains why criterial moralities tend to be minimalistic. They specify minimal sets of rules to follow in order to be moral. Pragmatism, on the other hand, like virtue theories, is more concerned to emphasize exemplary behavior – to use morally relevant features of action to determine the best way to behave, not the minimally tolerable way

#### [3] Performativity- Responding to our framework concedes the validity of agonism since that in and of itself is a process of contestation that agonism would say is valuable and necessary for spaces like debate to function.

#### [4] Rule Following Paradox- There is nothing inherent to a rule that tells us how we ought to follow it, regardless of how correct the rule is. Only deliberation accounts for the diversity of interpretations of our norms.

#### **[5]** Resolves Skepticism- a) Discussion between many bodies means that moral uncertainty can be deliberated and resolved. b) Truth only makes sense in groups of people so only they can prescribe action

#### [6] Liar’s Paradox – the resolution is always true

**Camus** [Albert Camus (existentialist). “The Myth of Sisyphus.” Penguin Books. 1975(originally published 1942). Accessed 12/11/19. Pg 22. Copy on hand. Houston Memorial DX]

The mind’s first step is to distinguish what is true from what is false. However, as soon as thought reflects on itself, what it first discovers is a contradiction. Useless to strive to be convincing in this case. Over the centuries no one has furnished a clearer and more elegant demonstration of the business than Aristotle: “The often ridiculed consequence of these opinions is that they destroy themselves. For by asserting that all is true we assert the truth of the contrary assertion and consequently the falsity of our own thesis (for the contrary assertion does not admit that it can be true). And if one says that all is false, that assertion is itself false. If we declare that solely the assertion opposed to ours is false or else that solely ours is not false, we are nevertheless forced to admit an infinite number of true or false judgments. For the one who expresses a true assertion proclaims simultaneously that it is true, and so on ad infinitum.”

#### [7] Overthinking paradox- the 1NC is a form of unnecessary overthinking that prevents decisions to be made so don’t evaluate it

**Wikipedia** [Brackets Original. “Analysis Paralysis”. Wikipedia. No Date. <https://en.wikipedia.org/wiki/Bonini%27s_paradox>]

Analysis paralysis (or paralysis by analysis) describes an individual or group process when overanalyzing or overthinking a situation can cause forward motion or decision-making to become [frozen] "paralyzed", meaning that no solution or course of action is decided upon. A situation may be deemed too complicated and a decision is never made, due to the fear that a potentially larger problem may arise. A person may desire a perfect solution, but may fear making a decision that could result in error, while on the way to a better solution. Equally, a person may hold that a superior solution is a short step away, and stall in its endless pursuit, with no concept of diminishing returns. On the opposite end of the time spectrum is the phrase extinct by instinct, which is making a fatal decision based on hasty judgment or a gut reaction.

#### [8] The rules of logic claim that the only time a statement is invalid is if the antecedent is true, but the consequent is false.

SEP [Stanford Encyclopedia of Philosophy.] “An Introduction to Philosophy.” Stanford University. <https://web.stanford.edu/~bobonich/dictionary/dictionary.html> TG Massa

Conditional statement: an “if p, then q” compound statement (ex. If I throw this ball into the air, it will come down); p is called the antecedent, and q is the consequent. A conditional asserts that if its antecedent is true, its consequent is also true; any conditional with a true antecedent and a false consequent must be false.  For any other combination of true and false antecedents and consequents, the conditional statement is true.

#### If the aff is winning, they get the ballot is a tacit ballot conditional which means denying the premise proves the conclusion that I should get the ballot.

#### [9] Principle of explosion is true which proves the resolution true.

**Wikiwand**. “Principle of Explosion.” Wikiwand, 0AD, [www.wikiwand.com/en/Principle\_of\_explosion](http://www.wikiwand.com/en/Principle_of_explosion). //Massa

A screenshot of a cell phone

Description automatically generated

The principle of explosion (Latin: ex falso (sequitur) quodlibet (EFQ), "from falsehood, anything (follows)", or ex contradictione (sequitur) quodlibet (ECQ), **"from contradiction, anything (follows)"), or the principle of**[**Pseudo-Scotus**](https://www.wikiwand.com/en/Pseudo-Scotus), is the law of [classical logic](https://www.wikiwand.com/en/Classical_logic), [intuitionistic logic](https://www.wikiwand.com/en/Intuitionistic_logic) and similar logical systems, according to which any statement can be proven from a contradiction.[[1]](https://www.wikiwand.com/en/Principle_of_explosion#citenote1) That is, once a contradiction has been asserted, any proposition (including their negations) can be inferred from it. This is known as **deductive explosion**.[[2]](https://www.wikiwand.com/en/Principle_of_explosion#citenote2)[[3]](https://www.wikiwand.com/en/Principle_of_explosion#citenote3) The proof of this principle was first given by 12th century French philosopher [William of Soissons](https://www.wikiwand.com/en/William_of_Soissons).[[4]](https://www.wikiwand.com/en/Principle_of_explosion#citenote4)

As a demonstration of the principle, **consider two contradictory statements – "All lemons are yellow" and "Not all lemons are yellow"**, and suppose that both are true. If that is the case, **anything can be proven**, e.g., **the assertion that "unicorns exist", by using the following argument:**

1. We know that **"All lemons are yellow"**, as it **has been assumed to be true.**
2. **Therefore**, the two-part statement **"All lemons are yellow OR unicorns exist” must also be true**, since the first part is true.
3. However, **since we know that "Not all lemons are yellow"** (as this has been assumed), **the first part is false, and hence the second part must be true, i.e., unicorns exist.**

#### [10] Dogmatism Paradox – disregard the 1NC

Sorensen Sorensen, Roy, Professor of Philosophy at Washington University in St. Louis. "Epistemic Paradoxes.” Stanford Encyclopedia of Philosophy. 21 June 2006. <https://plato.stanford.edu/entries/epistemic-paradoxes/>. PeteZ

Saul Kripke’s ruminations on the surprise test paradox led him to a paradox about dogmatism. He lectured on both paradoxes at Cambridge University to the Moral Sciences Club in 1972. (A descendent of this lecture now appears as Kripke 2011). Gilbert Harman transmitted Kripke’s new paradox as follows: If I know that h is true, I know that any evidence against h is evidence against something that is true; I know that such evidence is misleading. But I should disregard evidence that I know is misleading. So, once I know that h is true, I am in a position to disregard any future evidence that seems to tell against h. (1973, 148)

#### [11] Vote aff because it’s simple – evaluating responses to this is complicated so don’t

Baker 04’ [Baker, Alan, 10-29-2004, "Simplicity (Stanford Encyclopedia of Philosophy)," <https://plato.stanford.edu/entries/simplicity/>]

With respect to question (ii), there is an important distinction to be made between two sorts of simplicity principle. Occam's Razor may be formulated as an epistemic principle: if theory T is simpler than theory T\*, then it is rational (other things being equal) to believe T rather than T\*. Or it may be formulated as a methodological principle: if T is simpler than T\* then it is rational to adopt T as one's working theory for scientific purposes. These two conceptions of Occam's Razor require different sorts of justification in answer to question (iii). In analyzing simplicity, it can be difficult to keep its two facets—elegance and parsimony—apart. Principles such as Occam's Razor are frequently stated in a way which is ambiguous between the two notions, for example, “Don't multiply postulations beyond necessity.” Here it is unclear whether ‘postulation’ refers to the entities being postulated, or the hypotheses which are doing the postulating, or both. The first reading corresponds to parsimony, the second to elegance. Examples of both sorts of simplicity principle can be found in the quotations given earlier in this section.

#### [12] Affirm because either the neg is true meaning its bad for us to clash w/ it because it turns us into Fake News people OR it’s not meaning it’s a lie that you can’t vote on for ethics

#### [13] Decision Making Paradox- in order to judge we need a decision-making procedure to determine it is a good decision. But to chose a decision-making procedure requires another meta level decision making procedure leading to infinite regress so just vote aff to break the paradox.

#### [14] GCB- I am the greatest conceivable being so vote for me because I am infinitely good. To prove this, I will make them contest the aff and say they are not under my control.

#### [15] Negative arguments presuppose the aff being true since they begin with a descriptive premise about the affirmative such as the aff does x, and then justify why x is bad. However, if the aff does not have truth value, that entails the descriptive premise would also not have truth value, which is contradictory.

#### [16] Negating affirms because it assumes that the 1ac is a statement that is worthy of contestation which means are arguments are legitimate.

#### [17] Empirics- Quantum superposition proves different ethics can exist simultaneously.

MIT ’19 (Emerging Technology from the arXiv archive page; Covers latest ideas from blog post about arXiv; 03/12/2019; “Emerging Technology from the arXiv archive page”; <https://www.technologyreview.com/2019/03/12/136684/a-quantum-experiment-suggests-theres-no-such-thing-as-objective-reality/>; *MIT Technology Review*; accessed: 11/19/2020; MohulA)

Back in 1961, the Nobel Prize–winning physicist Eugene Wigner outlined a thought experiment that demonstrated one of the lesser-known paradoxes of quantum mechanics. The experiment shows how the strange nature of the universe allows two observers—say, Wigner and Wigner’s friend—to experience different realities. Since then, physicists have used the “Wigner’s Friend” thought experiment to explore the nature of measurement and to argue over whether objective facts can exist. That’s important because scientists carry out experiments to establish objective facts. But if they experience different realities, the argument goes, how can they agree on what these facts might be? That’s provided some entertaining fodder for after-dinner conversation, but Wigner’s thought experiment has never been more than that—just a thought experiment. Last year, however, physicists noticed that recent advances in quantum technologies have made it possible to reproduce the Wigner’s Friend test in a real experiment. In other words, it ought to be possible to create different realities and compare them in the lab to find out whether they can be reconciled. And today, Massimiliano Proietti at Heriot-Watt University in Edinburgh and a few colleagues say they have performed this experiment for the first time: they have created different realities and compared them. Their conclusion is that Wigner was correct—these realities can be made irreconcilable so that it is impossible to agree on objective facts about an experiment. Wigner’s original thought experiment is straightforward in principle. It begins with a single polarized photon that, when measured, can have either a horizontal polarization or a vertical polarization. But before the measurement, according to the laws of quantum mechanics, the photon exists in both polarization states at the same time—a so-called superposition. Wigner imagined a friend in a different lab measuring the state of this photon and storing the result, while Wigner observed from afar. Wigner has no information about his friend’s measurement and so is forced to assume that the photon and the measurement of it are in a superposition of all possible outcomes of the experiment. Wigner can even perform an experiment to determine whether this superposition exists or not. This is a kind of interference experiment showing that the photon and the measurement are indeed in a superposition. From Wigner’s point of view, this is a “fact”—the superposition exists. And this fact suggests that a measurement cannot have taken place. But this is in stark contrast to the point of view of the friend, who has indeed measured the photon’s polarization and recorded it. The friend can even call Wigner and say the measurement has been done (provided the outcome is not revealed). So the two realities are at odds with each other. “This calls into question the objective status of the facts established by the two observers,” say Proietti and co. That’s the theory, but last year Caslav Brukner, at the University of Vienna in Austria, came up with a way to re-create the Wigner’s Friend experiment in the lab by means of techniques involving the entanglement of many particles at the same time. The breakthrough that Proietti and co have made is to carry this out. “In a state-of-the-art 6-photon experiment, we realize this extended Wigner’s friend scenario,” they say. They use these six entangled photons to create two alternate realities—one representing Wigner and one representing Wigner’s friend. Wigner’s friend measures the polarization of a photon and stores the result. Wigner then performs an interference measurement to determine if the measurement and the photon are in a superposition. The experiment produces an unambiguous result. It turns out that both realities can coexist even though they produce irreconcilable outcomes, just as Wigner predicted. That raises some fascinating questions that are forcing physicists to reconsider the nature of reality. The idea that observers can ultimately reconcile their measurements of some kind of fundamental reality is based on several assumptions. The first is that universal facts actually exist and that observers can agree on them. But there are other assumptions too. One is that observers have the freedom to make whatever observations they want. And another is that the choices one observer makes do not influence the choices other observers make—an assumption that physicists call locality. If there is an objective reality that everyone can agree on, then these assumptions all hold. But Proietti and co’s result suggests that objective reality does not exist. In other words, the experiment suggests that one or more of the assumptions—the idea that there is a reality we can agree on, the idea that we have freedom of choice, or the idea of locality—must be wrong. Of course, there is another way out for those hanging on to the conventional view of reality. This is that there is some other loophole that the experimenters have overlooked. Indeed, physicists have tried to close loopholes in similar experiments for years, although they concede that it may never be possible to close them all. Nevertheless, the work has important implications for the work of scientists. “The scientific method relies on facts, established through repeated measurements and agreed upon universally, independently of who observed them,” say Proietti and co. And yet in the same paper, they undermine this idea, perhaps fatally. The next step is to go further: to construct experiments creating increasingly bizarre alternate realities that cannot be reconciled. Where this will take us is anybody’s guess. But Wigner, and his friend, would surely not be surprised.

### 1AC – Offense

#### I affirm -  The member nations of the World Trade Organization ought to reduce intellectual property protections for medicines by implementing a one-and-done approach for patent and exclusivity protection.

Feldman 3 Robin Feldman 2-11-2019 "‘One-and-done’ for new drugs could cut patent thickets and boost generic competition" <https://www.statnews.com/2019/02/11/drug-patent-protection-one-done/> (Arthur J. Goldberg Distinguished Professor of Law, Albert Abramson ’54 Distinguished Professor of Law Chair, and Director of the Center for Innovation)//SidK + Elmer

I believe that one period of protection **should be enough**. We should make the legal changes necessary to prevent companies **from building patent walls** and piling up mountains of rights. This could be accomplished **by a “one-and-done” approach** for patent protection. Under it, a drug would receive just one period of exclusivity, and no more. The choice of which “one” could be left entirely in the hands of the pharmaceutical company, with the election made when the FDA approves the drug. Perhaps development of the drug went swiftly and smoothly, so the remaining life of one of the drug’s patents is of greatest value. Perhaps development languished, so designation as an orphan drug or some other benefit would bring greater reward. The choice would be up to the company itself, based on its own calculation of the maximum benefit. The result, however, is that a pharmaceutical company chooses whether its period of exclusivity would be a patent, an orphan drug designation, a period of data exclusivity (in which no generic is allowed to use the original drug’s safety and effectiveness data), or something else — but **not all of the above** and more. Consider Suboxone, a combination of buprenorphine and naloxone for treating opioid addiction. The drug’s maker has extended its protection cliff eight times, including obtaining an orphan drug designation, which is intended for drugs that serve only a small number of patients. The drug’s first period of exclusivity ended in 2005, but with the additions its protection now lasts until 2024. That makes almost two additional decades in which the public has borne the burden of monopoly pricing, and access to the medicine may have been constrained. Implementing a one-and-done approach in conjunction with FDA approval underscores the fact that these problems and solutions are designed for pharmaceuticals, not for all types of technologies. That way, one-and-done could be implemented through **legislative changes to the FDA’s drug approval system**, and would apply to patents granted going forward. One-and-done would apply to both patents and exclusivities. A more limited approach, a baby step if you will, would be to invigorate the existing patent obviousness doctrine as a way to cut back on patent tinkering. Obviousness, one of the five standards for patent eligibility, says that inventions that are obvious to an expert or the general public can’t be patented. Either by congressional clarification or judicial interpretation, many pile-on patents could be eliminated with a ruling that the core concept of the additional patent is nothing more than the original formulation. Anything else is merely an obvious adaptation of the core invention, modified with existing technology. As such, the patent would fail for being perfectly obvious. Even without congressional action, a more vigorous and robust application of the existing obviousness doctrine could significantly improve the problem of piled-up patents and patent walls. Pharmaceutical companies have become adept at maneuvering through the system of patent and non-patent rights to create mountains of rights that can be applied, one after another. This behavior lets drug companies keep competitors out of the market and beat them back when they get there. We shouldn’t be surprised at this. Pharmaceutical companies are profit-making entities, after all, that face pressure from their shareholders to produce ever-better results. If we want to change the system, we must change the incentives driving the system. And right now, the incentives for creating patent walls are just too great.

#### Counter solvency advcoates in the doc

<https://www.who.int/intellectualproperty/submissions/Pharmacoevolution.pdf?ua=1>

https://pubs.acs.org/doi/10.1021/acsmedchemlett.9b00497

#### Resolved is defined as[[1]](#footnote-1) firm in purpose or intent; determined and I’m determined.

#### Affirm means to express agreement[[2]](#footnote-2) and you already know I do.

#### [1] Reducing IP is a method of global solidarity by manifesting intra-country cooperation.

Jecker and Atuire 7/7 [Nancy S Jecker (professor of bioethics and philosophy at the University of Washington School of Medicine, Department of Bioethics and Humanities) and Caesar A Atuire (PhD in Philosophy from the Athenaeum Regina Apostolorum, Rome, Lecturer in the Department of Philosophy and Classics at the University of Ghana, Legon). “What’s yours is ours: waiving intellectual property protections for COVID-19 vaccines”. Journal of Medical Ethics. July 7 2021. Accessed 7/22/21. <https://jme.bmj.com/content/early/2021/07/06/medethics-2021-107555> //Xu]

We turn next to positive ethical arguments for temporarily waiving IP protections, which appeal to the values of globally solidarity and corporate responsibility. Global solidarity underscores that during the COVID-19 pandemic, each nation’s interests are entwined with the interests of every other.22 Just as it is impossible for any nation standing alone to address the threat to human health climate change raises, it is impossible for any single nation to meet the challenge that COVID-19 and future pandemics present. Instead, humanity must stand together. In the past, nations have failed to do so. The epidemic of HIV/AIDS in Africa illustrates. Shamefully, it took nearly a decade for the first antiretroviral drugs to reach the African continent, even though Africa was the hardest hit region and antiretroviral drugs provided 90% mortality reduction. Although the US government was an early investor in research that produced antiviral drugs for HIV, distribution was controlled by big pharmaceutical companies driven by profit. The USA and other wealthy countries repeated this mistake during the COVID-19 pandemic, supporting vaccine developers without requiring technology transfers and donations to COVAX (the multilateral partnership supplying vaccines to LMICs). Ethically, the task ahead is fixing a problem of human making. A second argument, based on corporate social responsibility, stresses expectations for and benefits of socially responsible behaviour by for-profit companies. Increasingly, companies appreciate the potential impact that socially responsible behaviour has on competitive advantage, reputation, retention of workers and customers, employee morale and relationships with stakeholders.23 IP protections shield pharmaceutical companies from competition, enabling them to monopolise markets and generate above-normal profits. During a pandemic, social responsibility requires temporarily limiting profits and requiring companies to give back, rather than allowing above-normal profits to accrue unchecked. Even Locke, who conceived of our modern notion of property rights, held that fundamental rights like property could be justly overridden under certain conditions, namely, when the goods are perishable and would go to waste or when their extraction may intrude on the common good, in which case they extend only to what leaves enough behind for others.24 Building on this analysis, we submit that displays of social responsibility fall along a continuum. During the COVID-19 pandemic, a high degree of responsibility would be shown by temporarily sharing patents for products aimed at preventing, containing, or treating COVID-19, which is India and South Africa’s proposal; moderate responsibility would be demonstrated by temporarily sharing licenses to manufacture COVID-19 vaccines, as the WTO Director General proposes; and minimal responsibility would be shown by sending vaccines directly to nations in response to pleas for help, which Pfizer did when it pledged up to 40 million doses of its vaccine to COVAX (which represents under 2% of the 2.5 billion doses Pfizer will produce in 2021).25

### 1AC – Underview

#### [1] 1AR theory is legit – anything else means infinite abuse – drop the debater, competing interps, no rvis– 1AR is too short to make up for the time trade-off – no RVIs or 2NR theory and paradigm issues– 6 min 2NR means they can brute force me every time, which is also a reason to evaluate theory after the 1ar.

#### [2] No 2NR “I meet” arguments

#### A] Skews theory ground because they’re each a NIB for me to winning theory which kills my ability to check abuse.

#### B] Skews time, they can make three minutes of blippy I meets that I can’t cover because the 2AR is too short.

#### [3] No neg analytics - I don’t have time to cover 100 blippy arguments in the NC since you can read 7 min of analytics and extend any of them to win.

#### [4] No neg arguments – skews me to answer those. Answering this triggers a contradiction since it relies on an analytic argument and those affirm since I spoke first and they were your fault for creating.

#### [5] The neg may not read meta-theory – I only have time to check abuse 1 time but you can do it in the NC and 2N, up-layering my attempt means we never get to the best norm. This means reject any reason why an aff spike is bad since they claim aff theory is unfair.

#### [6] The neg may not read overview answers to aff arguments – they can up-layer all aff arguments for 7 minutes and the 1ar has to shift through it all. I have a computer virus that prevents changing font size and everything’s in an overview.

#### [7] They must call me “Kaps” in cross examination, anything else incentivizes psychological violence which is a reason to reject them

### 1AC – Advantage 1

#### We are in an innovation crisis – new drugs are not being developed in favor of re-purposing old drugs to infinitely extend patent expiration.

Feldman 1 Robin Feldman 2-11-2019 "‘One-and-done’ for new drugs could cut patent thickets and boost generic competition" <https://www.statnews.com/2019/02/11/drug-patent-protection-one-done/> (Arthur J. Goldberg Distinguished Professor of Law, Albert Abramson ’54 Distinguished Professor of Law Chair, and Director of the Center for Innovation)//SidK + Elmer

Drug companies **have brought great innovations** to market. Society rewards innovation with patents, or with non-patent exclusivities that can be obtained for activities such as testing drugs in children, undertaking new clinical studies, or developing orphan drugs. The rights provided by patents or non-patent exclusivities provide a defined time period of protection so companies can recoup their investments by charging monopoly prices. When patents end, lower-priced competitors should be able to jump into the market and drive down the price. **But that’s not happening**. Instead, drug companies build massive patent walls around their products, extending the protection **over and over again**. Some modern drugs have an avalanche of U.S. patents, with expiration dates **staggered across time**. For example, the rheumatoid arthritis drug Humira is **protected by more than 100 patents**. Walls like that **are insurmountable**. Rather than rewarding innovation, our patent system is now largely repurposing drugs. Between 2005 and 2015, **more than three-quarters** of the drugs associated with new patents **were not new ones** coming on the market but existing ones. In other words, we are mostly churning and recycling. Particularly troubling, new patents can be **obtained on minor tweaks** such as adjustments to dosage or delivery systems — a once-a-day pill instead of a twice-a-day one; a capsule rather than a tablet. Tinkering like this may have some value to some patients, but it nowhere near justifies the rewards we lavish on companies for doing it. From society’s standpoint, incentives should drive scientists back to the lab to look for new things, not to recycle existing drugs for minimal benefit.

#### The only major study confirms our Internal Link – Evergreening decimates competition by resulting in functional monopolies

Arnold Ventures 20 9-24-2020 "'Evergreening' Stunts Competition, Costs Consumers and Taxpayers" <https://www.arnoldventures.org/stories/evergreening-stunts-competition-costs-consumers-and-taxpayers/> (Arnold Ventures is focused on evidence-based giving in a wide range of categories including: criminal justice, education, health care, and public finance)//Elmer

In 2011, Elsa Dixler was diagnosed with multiple myeloma. That August, she was prescribed Revlimid, a drug that had come on the market six years earlier. By January 2012, she went into full remission, where she has remained since. So long as Revlimid retains its effectiveness, she will take it for the rest of her life. “I was able to go back to work, see my daughter receive her Ph.D, and have a pretty normal life,” said Dixler, a Brooklyn resident who is now 74. “So, on the one hand, I feel enormously grateful.” But Dixler’s normal life has come at a steep financial cost to her family and to taxpayers. Revlimid typically costs nearly $800 per capsule, and Dixler takes one capsule per day for 21 days, then seven days off, and then resumes her daily dose, requiring 273 capsules a year. Since retiring from The New York Times at the end of 2017, she has been on Medicare. Dixler entered the Part D coverage gap (known as the donut hole) “within minutes,” she said. She estimates that adding her deductible, her copayment of $12,000, and what her Part D insurance provider pays totals approximately $197,500 a year. Revlimid should have **been subject to competition** from generic drug makers starting in 2009, bringing down its cost by many orders of magnitude. But by obtaining **27 additional patents**, eight orphan drug exclusivities and 91 total additional protections from the U.S. Food and Drug Administration (FDA) since Revlimid’s introduction in 2005, its manufacturer, Celgene, has extended the drug’s **monopoly** **period** **by 18 years** — through March 8, 2028. “I cannot fathom the immorality of a business that relies on **squeezing people with cancer**,” Dixler said, noting her astonishment that Revlimid has obtained orphan drug protections when it treats a disease that is not rare and does not serve a very limited population. She also observed that Revlimid’s underlying drug is thalidomide, which has been around for decades. “They didn’t invent a new drug, rather, they found a new use for it,” she said. “The cost of Revlimid has imposed constraints on our retirement,” Dixler said, “but when I hear other people’s stories, I feel very lucky. A lot of people have been devastated financially.” Revlimid is a case study in a process known as “evergreening” — artificially sustaining a monopoly for years and even decades by manipulating intellectual property laws and regulations. Evergreening is most commonly used with blockbuster drugs generating the highest prices and profits. **Of the roughly 100 best-selling drugs, more than 70 percent have extended their protection** from competition at least once. More than half have extended the protection cliff multiple times. The true scope and cost of evergreening has been brought into sharper focus by a groundbreaking, publicly available, comprehensive database released Thursday by the Center for Innovation at the University of California Hastings College of Law and supported by Arnold Ventures. **The Evergreen Drug Patent Search is the first database to exhaustively track the patent protections filed by pharmaceutical companies**. Using data from 2005 to 2018 on brand-name drugs listed in the FDA’s Orange Book — a listing of relevant patents for brand name, small molecule drugs — it demonstrates the full extent of how evergreening has been used by Big Pharma to prolong patents and delay the entry of generic, lower-cost competition. “Competition is the backbone of the U.S. economy,” said Professor Robin Feldman, Director of the UC Hastings Center for Innovation, who spearheaded the database’s creation. “But it’s not what we’re seeing in the drug industry. “With evergreening, pharmaceutical companies repeatedly make slight, often trivial, modifications to drugs, dosage levels, delivery systems or other aspects to obtain new protections,” she said. “They pile these protections on over and over again — so often that 78 percent of the drugs associated with new patents were not new drugs coming on the market, but existing drugs.” Competition is the backbone of the U.S. economy. But it’s not what we’re **seeing in the drug industry**. Professor Robin Feldman Director of the UC Hastings Center for Innovation In recent decades, evergreening has systematically undermined the Drug Price Competition and Patent Term Restoration Act of 1984, which created the generic drug industry. Commonly known as the Hatch-Waxman Act, it established a new patent and market exclusivity regime in which new drugs are protected from competition for a specified period of time sufficient to allow manufacturers to recoup their investments and earn a reasonable profit. When that protection expires, generic drug makers are incentivized to enter the market through a streamlined regulatory and judicial process. Drug prices typically drop by as much as 20 percent when the first generic enters the market**, and with more than one generic manufacturer, prices can plummet by 80 to 85 percent**. “Hatch-Waxman created an innovation/reward/competition cycle, but it’s been distorted into an innovation/reward/more reward cycle,” Feldman said. “To paraphrase something a former FDA commissioner once said, the greatest creativity in Big Pharma should come from the research and development departments, not from the legal and marketing departments.” Feldman led the development of the Evergreen Drug Patent Search in response to repeated requests from Congressional committees, members of Congress, state regulators and journalists for information about specific drugs and companies. “We want to make it so anyone can have the question about drug protections at their fingertips whenever they want,” Feldman said. “It’s designed to be easy and user-friendly, and to enhance public understanding about how competition may be limited rather than enhanced through the drug patent system.” The **database** was **created through** a painstaking process of **combing** through **160,000 data points** **to examine every instance where a pharmaceutical company added a new drug patent or exclusivity**. “Most of it was done by hand,” Feldman said, “with multiple people reviewing it at every stage. And along the way we repeatedly made conservative choices. **We erred on the side of underrepresenting the evergreen gain** to be sure we were as fair and reasonable as possible.” Among the 2,065 drugs covered in Evergreen Drug Patent Search, there are many examples of the evergreening strategy used by pharma to delay the entry of competition, especially generics, often for widely prescribed drugs, including those used to treat heartburn, chronic pain, and opioid addiction. Nexium Before Nexium, there was Prilosec, a popular drug to treat gastroesophageal reflux disease (GERD). But its patent exclusivity was due to expire in April 2001. In the late 1990s, with a precipitous drop in revenue looming, Prilosec’s manufacturer, AstraZeneca, decided to develop a replacement drug. Using “one-half of the Prilosec molecule — an isomer of it,” the result was Nexium, which received approval in February 2001. Essentially an evergreened version of Prilosec, Nexium’s exclusivity was then extended by more than 15 years, as AstraZeneca received 97 protections stemming from 16 patents. These included revised dosages, compounds, and formulations. Feldman said that tinkering changes such as Nexium’s do not involve the substantial research and development required for a new drug, nor do they constitute true innovations, yet for a decade and a half, patients and taxpayers were forced to pay far more than was warranted for GERD relief. In fact, in 2016 — one year after patent exclusivity expired — Nexium still topped all drugs in Medicare Part D spending, totaling $1.06 billion. Suboxone Use of this combination of buprenorphine and naloxone for treating opioid addiction has exploded in the wake of the opioid epidemic. Since its approval, Suboxone’s manufacturer, Reckitt Benckiser (now operating as Indivior), extended its protection cliff eight times, gaining nearly two extra decades of exclusivity through early 2030. The drug maker gained six patents for creating a film version of the drug — notably around the time protection was expiring for its tablet version. (The therapeutic benefits of the film and tablet are identical.) An earlier version of Suboxone also obtained an orphan drug designation, despite an opioid epidemic that has expanded Suboxone’s customer base to millions of potential customers. Suboxone generates more than $1 billion in annual revenue and ranks among the 40 top-selling drugs in the U.S. Truvada When Truvada, commonly referred to as PrEP, was approved in 2004, this HIV-prevention drug was a breakthrough. But 16 years later — and 14 years after its original exclusivity was to expire — it retains its monopoly status. Truvada’s manufacturer, Gilead, has received 15 patents and 120 protections since it came on the market, extending its exclusivity for more than 17 years, until July 3, 2024. In countries where generic Truvada is available, PrEP costs $100 or less per month, compared to $1,600 to $2,000 in the U.S. As a result, Truvada is unaffordable to many people **who need protection from HIV**. Barred from access, they are left vulnerable to infection. “We’re establishing a precedent that a pharmaceutical company can charge whatever it wants even as it allows an epidemic to continue, and the government refuses to intervene,” said James Krellenstein, co-founder of the group PrEP4All. “That should scare every American. If it’s HIV today, it will be another disease tomorrow.” EpiPen First approved in 1987, the EpiPen has saved the lives of countless numbers of people with deadly allergies. But it is protected from competition until 2025 — 38 years after its introduction — because its owner, Mylan, has filed five patents, four since 2010, all involving tweaks to the automatic injector. The actual medication used, epinephrine, has existed for more than a century — the innovation here is in the delivery device. Because these small changes to the injector have maintained its monopoly for so long, the cost of an EpiPen package (containing two injectors) has risen from $94 when Mylan purchased the device to between $650 and $700 today. For many people, especially parents of children with severe reactions to common allergens like peanuts, EpiPen’s increasing price tag imposes an onerous financial burden. What Can Be Done As the Evergreen Drug Patent Search makes clear, the positive impact of Hatch-Waxman has been steadily and severely eroded by a regulatory system vulnerable to increasingly sophisticated forms of manipulation. “You might say that the patent and regulatory system has been weaponized,” Feldman said. “When billions of dollars are at stake, there’s a lot of money available to look for ways to exploit the legal system. And companies have become adept at this, as our work has found.” There are several key steps that Congress could take to restore the balance between innovation and competition that is the key to a successful prescription drug regulatory process. These may include: Imposing restrictions on the number of patents that prescription drug manufacturers can defend in court to discourage the use of anticompetitive patent thickets. Limiting the patentability of so-called secondary patents — which don’t improve the safety or efficacy of a drug — through patent and exclusivity reform. Reforming the 180-day generic exclusivity, which can currently be abused to block other competitive therapies. “**The Evergreen Drug Patent Search provides the publicly available, evidence-based foundation that defines the extent of the problem**, and it can be used to develop policies that solve the problem of anti-competitive patent abuses,” said Kristi Martin, VP of Drug Pricing at Arnold Ventures. “Our incentives have gotten out of whack,” Martin said. “The luxury of monopoly protection should only be provided to innovations that provide meaningful benefits in saving lives, curing illnesses, or improving the quality of people’s lives. It should not be provided to those gaming the system. If we can change that, we can save consumers, employers, and taxpayers many billions of dollars while increasing the incentives for pharmaceutical companies to achieve breakthroughs."

#### Only innovation now solves AMR super-bugs -- timeframe’s key.

Sobti 19 [Dr. Navjot Kaur Sobti is an internal medicine resident physician at Dartmouth-Hitchcock-Medical Center/Dartmouth School of Medicine and a member of the ABC News Medical Unit. May 1, 2019. “Amid superbug crisis, scientists urge innovation”. <https://abcnews.go.com/Health/amidst-superbug-crisis-scientists-urge-innovation/story?id=62763415>] Dhruv

[The United Nations](https://abcnews.go.com/Politics/amal-clooney-angelina-jolie-speak-us-weighed-vetoing/story?id=62574726) has called antimicrobial resistance a “global crisis.” With the [rise in superbugs](https://abcnews.go.com/Health/superbug-fungus-global-health-threat-600-us-infected/story?id=62297532) across the globe, common infections are becoming harder to treat, and lifesaving procedures riskier to perform. Drug-resistant infections result in about 700,000 deaths per year, with at least 230,000 of those deaths due to multidrug resistant tuberculosis, [according to a groundbreaking report from the World Health Organization (WHO).](https://www.who.int/antimicrobial-resistance/interagency-coordination-group/IACG_final_report_EN.pdf?ua=1) Given that antibiotic resistance is present in every country, antimicrobial resistance (AMR) now represents a global health crisis, according to the UN, which has urged immediate, coordinated and global action to prevent a potentially devastating health and financial crisis. With the rising rates of AMR -- including antivirals, antibiotics, and antifungals -- estimates from the WHO show that AMR may cause 10 million deaths every year by 2050, send 24 million people into extreme poverty by 2030, and lead to a financial crisis as severe as the on the U.S. experienced in 2008. Antimicrobial resistance develops when germs like bacteria and fungi are able to “defeat the drugs designed to kill them,” according to the Centers for Disease Control and Prevention. Through a biologic “survival of the fittest,” germs that are not killed by antimicrobials and continue to grow. WHO explains that “poor infection control, inadequate sanitary conditions and inappropriate food handling encourage the spread” of AMR, which can lead to “superbugs.” Those superbugs require powerful and oftentimes more expensive antimicrobials to treat. Examples of superbugs are far and wide, and can range from drug-resistant bacteria like Pseudomonas aeruginosa and Staphylococcus aureus to fungi like Candida. These bugs can cause illnesses that range from pneumonia to urinary tract and sexually transmitted infections. According to the WHO, AMR has caused complications for nearly 500,000 people with tuberculosis, and a number of people with HIV and malaria. The people at the [highest risk for AMR](https://www.who.int/news-room/detail/27-02-2017-who-publishes-list-of-bacteria-for-which-new-antibiotics-are-urgently-needed) are those with chronic diseases, people living in nursing homes, hospitalized in the ICU or undergoing life-saving treatments such as organ transplantation and cancer therapy. These people often develop infections, which can become antimicrobial-resistant, rendering them difficult, if not impossible, to treat. [(MORE: Melissa Rivers talks about her father's suicide with Dr. Jennifer Ashton)](https://abcnews.go.com/Health/melissa-rivers-talks-fathers-suicide-dr-jennifer-ashton/story?id=62733179&cid=clicksource_26_null_headlines_hed) The CDC notes that “antibiotic resistance has the potential to affect people at any stage of life,” including the “healthcare, veterinary, and agriculture industries, making it one of the world’s most urgent public health problems." AMR can cause prolonged hospital stays, billions of dollars in healthcare costs, disability, and potentially, death. “The most important thing is to understand and embrace the interconnectedness of all of this,” said Dr. Robert Redfield, director of the CDC, in a recent interview with ABC News’ Dr. Jennifer Ashton. It’s not just our countries that are connected.” Research has shown that superbugs like Candida auris “came from multiple places, at the same time. It wasn’t just one organism that [evolved]” in a single location, Redfield added. Given longstanding concerns about antimicrobial misuse leading to AMR, physicians have embraced a medical approach called antibiotic stewardship. This encourages physicians to carefully evaluate which antibiotic is most appropriate for their patient, and discontinue it once it is no longer medically needed. WHO has also highlighted that the inappropriate use of antimicrobials in agriculture -- such as on farms and in animals -- may be an underappreciated cause of AMR. Noting these trends, the WHO has urged for “coordinated action...to minimize the emergence and spread of antimicrobial resistance.” It urges all countries to make national action plans, with a focus on the development of new antimicrobial medications, vaccines, and careful antimicrobial use. Redfield emphasized the importance of vaccination during the global superbug crisis, stating that “the only way we have to eliminate an infection is vaccination.” He added that investing in innovation is key to solving the crisis. While WHO continues to advocate for superbug awareness, they warn that AMR has reversed “a century of progress in health.” The WHO added that “the challenges of antimicrobial resistance” are “not insurmountable,” and that coordinated action will “help to save millions of lives, preserve antimicrobials for generations to come and secure the future from drug-resistant diseases.”

#### Extinction - generic defense doesn’t apply.

Srivatsa 17 Kadiyali Srivatsa 1-12-2017 “Superbug Pandemics and How to Prevent Them” <https://www.the-american-interest.com/2017/01/12/superbug-pandemics-and-how-to-prevent-them/> (doctor, inventor, and publisher. He worked in acute and intensive pediatric care in British hospitals)//Elmer

It is by now no secret that the human species is locked in a race of its own making with “superbugs.” Indeed, if popular science fiction is a measure of awareness, the theme has pervaded English-language literature from Michael Crichton’s 1969 Andromeda Strain all the way to Emily St. John Mandel’s 2014 Station Eleven and beyond. By a combination of massive inadvertence and what can only be called stupidity, we must now invent new and effective antibiotics faster than deadly bacteria evolve—and regrettably, they are rapidly doing so with our help. I do not exclude the possibility that bad actors might deliberately engineer deadly superbugs.1 But even if that does not happen, humanity faces an existential threat largely of its own making in the absence of malign intentions. As threats go, this one is entirely predictable. The concept of a “black swan,” Nassim Nicholas Taleb’s term for low-probability but high-impact events, has become widely known in recent years. Taleb did not invent the concept; he only gave it a catchy name to help mainly business executives who know little of statistics or probability. Many have embraced the “black swan” label the way children embrace holiday gifts, which are often bobbles of little value, except to them. But the threat of inadvertent pandemics is not a “black swan” because its probability is not low. If one likes catchy labels, it better fits the term “gray rhino,” which, explains Michele Wucker, is a high-probability, high-impact event that people manage to ignore anyway for a raft of social-psychological reasons.2 A pandemic is a quintessential gray rhino, for it is no longer a matter of if but of when it will challenge us—and of how prepared we are to deal with it when it happens. We have certainly been warned. The curse we have created was understood as a possibility from the very outset, when seventy years ago Sir Alexander Fleming, the discoverer of penicillin, predicted antibiotic resistance. When interviewed for a 2015 article, “The Most Predictable Disaster in the History of the Human Race, ” Bill Gates pointed out that one of the costliest disasters of the 20th century, worse even than World War I, was the Spanish Flu pandemic of 1918-19. As the author of the article, Ezra Klein, put it: “No one can say we weren’t warned. And warned. And warned. A pandemic disease is the most predictable catastrophe in the history of the human race, if only because it has happened to the human race so many, many times before.”3 Even with effective new medicines, if we can devise them, we must contain outbreaks of bacterial disease fast, lest they get out of control. In other words, we have a social-organizational challenge before us as well as a strictly medical one. That means getting sufficient amounts of medicine into the right hands and in the right places, but it also means educating people and enabling them to communicate with each other to prevent any outbreak from spreading widely. Responsible governments and cooperative organizations have options in that regard, but even individuals can contribute something. To that end, as a medical doctor I have created a computer app that promises to be useful in that regard—of which more in a moment. But first let us review the situation, for while it has become well known to many people, there is a general resistance to acknowledging the severity and imminence of the danger. What Are the Problems? Bacteria are among the oldest living things on the planet. They are masters of survival and can be found everywhere. Billions of them live on and in every one of us, many of them helping our bodies to run smoothly and stay healthy. Most bacteria that are not helpful to us are at least harmless, but some are not. They invade our cells, spread quickly, and cause havoc that we refer to generically as disease. Millions of people used to die every year as a result of bacterial infections, until we developed antibiotics. These wonder drugs revolutionized medicine, but one can have too much of a good thing. Doctors have used antibiotics recklessly, prescribing them for just about everything, and in the process helped to create strains of bacteria that are resistant to the medicines we have. We even give antibiotics to cattle that are not sick and use them to fatten chickens. Companies large and small still mindlessly market antimicrobial products for hands and home, claiming that they kill bacteria and viruses. They do more harm than good because the low concentrations of antimicrobials that these products contain tend to kill friendly bacteria (not viruses at all), and so clear the way for the mass multiplication of surviving unfriendly bacteria. Perhaps even worse, hospitals have deployed antimicrobial products on an industrial scale for a long time now, the result being a sharp rise in iatrogenic bacterial illnesses. Overuse of antibiotics and commercial products containing them has helped superbugs to evolve. We now increasingly face microorganisms that cannot be killed by antibiotics, antifungals, antivirals, or any other chemical weapon we throw at them. Pandemics are the major risk we run as a result, but it is not the only one. Overuse of antibiotics by doctors, homemakers, and hospital managers could mean that, in the not-too-distant future, something as simple as a minor cut could again become life-threatening if it becomes infected. Few non-medical professionals are aware that antibiotics are the foundation on which nearly all of modern medicine rests. Cancer therapy, organ transplants, surgeries minor and major, and even childbirth all rely on antibiotics to prevent infections. If infections become untreatable we stand to lose most of the medical advances we have made over the past fifty years. And the problem is already here. In the summer of 2011, a 43-year-old woman with complications from a lung transplant was transferred from a New York City hospital to the Clinical Center at the National Institutes of Health (NIH), in Bethesda, Maryland. She had a highly resistant superbug known as Klebsiella pneumoniae carbapenemase (KPC). The patient was treated and eventually discharged after doctors concluded that they had contained the infection. A few weeks later, a 34-year-old man with a tumor and no known link to the woman contracted KPC while at the hospital. During the course of the next few months, several more NIH patients presented with KPC. Doctors attacked the outbreak with combinations of antibiotics, including a supposedly powerful experimental drug. A separate intensive care unit for KPC patients was set up and robots disinfected empty rooms, but the infection still spread beyond the intensive care area. Several patients died and then suddenly all was silent on the KPC front, with doctors convinced they had seen the last of the dangerous bacterium. They couldn’t have been more mistaken. A year later, a young man with complications from a bone marrow transplant arrived at NIH. He became infected with KPC and died. This superbug is now present in hospitals in most, if not all U.S. states. This is not good. This past year an outbreak of CRE (carbapenem-resistant enterobacteriaceae) linked to contaminated medical equipment infected 11 patients and killed two in Los Angeles area hospitals. This family of bacteria has evolved resistance to all antibiotics, including the powerful carbapenem antibiotics that are often used as a last resort against serious infections. They are now so resilient that it is virtually impossible to remove them from medical tools such as catheters and breathing tubes placed into the body, even after cleaning. Then we have gonorrhea, chlamydia, and other sexually transmitted diseases that we cannot treat and that are spreading all over the world. Anyone who has sex can catch these infections, and because most people may not exhibit any symptoms they spread infections without anyone knowing about it. Sexually transmitted diseases used to be treatable with antibiotics, but in recent years we have witnessed the rise of multi-drug resistant STDs. Untreated gonorrhea can lead to infertility in men and women and blindness and other congenital defect in babies. As is well known, too, we have witnessed many cases of drug-resistant pneumonia. These problems have arisen in part because of simple mistakes healthcare professionals repeatedly make. Let me explain. Neither superbugs nor common bacterial infections produce any special symptoms indicative of their cause. Rashes, fevers, sneezing, runny noses, ear pain, diarrhea, vomiting, coughing, fatigue, and weakness are signs of common and minor illnesses as well as uncommonly deadly ones. Therefore, the major problem for clinicians is to identify a common symptom that may potentially be an early sign of a major infection that could result in an epidemic. We know that dangerous infections in any given geographical area do not start at the same time. They start with one victim and gradually spread. But that victim is only one among hundreds of patients a doctor will typically see, so many doctors will miss patients presenting with infections that are serious. They will probably identify diseases that kill fast, but slow-spreading infections such as skin infections that can lead to septicemia are rarely diagnosed early. In addition, I have seen doctors treating eczema with antibiotic cream, even though they know that bacteria are resistant to the majority of these drugs. This sort of action encourages simple infections to spread locally, because patients are therefore not instructed to take other, more useful precautions. On top of that, some people are frivolous about infections and assume doctors are exaggerating the threat. And some people are selfish. Once I was called to see a passenger during a flight who had symptoms consistent with infection. He boarded the plane with these symptoms, but began to feel much worse during the flight. I was scared, knowing how infections such as Ebola can spread. This made me think about a way to screen passengers before they board a flight. Airlines could refund a traveler’s ticket, or issue a replacement, in case of sickness—which is not the policy now. We currently have no method to block infectious travelers from boarding flights, and there are no changes in the incentive system to enable conscientious passengers to avoid losing their money if they responsibly miss a flight because of illness. Speaking of selfishness, I once saw a mother drop her daughter off at school with a serious bout of impetigo on her face. When I asked her why she had brought her daughter to school with a contagious infection, she said she could not spare the time to keep her at home or take her to the doctor. By allowing this child to contact other children, a simple infection can become a major threat. Fortunately, I could see the rash on the girl’s face, but other kids in schools may have rashes we cannot see. Incorrect diagnosis of skin problems and mistaken use of antibiotics to treat them is common all over the world, and so we are continually creating superbugs in our communities. Similarly, chest infections, sore throats, and illnesses diagnosed as colds that unnecessarily treated with antibiotics are also a major threat. By prescribing antibiotics for viral infections, we are not only helping bacteria develop resistance, but we are also polluting the environment when these drugs are passed in urine and feces. All of this helps resistant bacteria to spread in the community and become an epidemic. Ebola is very difficult to transmit because people who are contagious have visible and unusual symptoms. However, the emerging infections and pandemics of the future may not have visible symptoms, and they could break out in highly populous countries such as India and China that send thousands of travelers all over the world every day. When a person is infected with a contagious disease, he or she can expect to pass the illness on to an average of two people. This is called the “reproduction number.” Two is not that high a number as these things go; some diseases have far greater rates of infection. The SARS virus had a reproduction number of four. Measles has a reproduction number of 18. One person traveling as an airplane passenger and carrying an infection similar to Ebola can infect three to five people sitting nearby, ten if he or she walks to the toilet. The study that highlighted this was published in a medical journal a few years ago, but the airline industry has not implemented any changes or introduced screening to prevent the spread of infections by air travel passengers, a major vehicle for the rapid spread of disease. It is scary to think that nobody knows what will happen when the world faces a lethal disease we’re not used to, perhaps with a reproduction number of five or eight or even ten. What if it starts in a megacity? What if, unlike Ebola, it’s contagious before patients show obvious symptoms? Past experience isn’t comforting. In 2009, H1N1 flu spread around the world before we even knew it existed. The Questions Remains Why do seemingly intelligent people repeatedly do such collectively stupid things? How did we allow this to happen? The answer is disarmingly simple. It is because people are incentivized to prioritize short-term benefits over long-term considerations. It is what social scientists have called a “logic of collective action” problem. Everyone has his or her specialized niche interest: doctors their patients’ approval, business and airline executives their shareholders’ earnings, hospitals their reputations for best-practice hygienics, homemakers their obligation to keep their own families from illness. But no one owns the longer-term consequences for hundreds of millions of people who are irrelevant to satisfying these short-term concerns. Here is an example. At a recent Superbug Super Drug conference in London that I attended, scientists, health agencies, and pharmaceutical companies were vastly more concerned with investing millions of dollars in efforts to invent another antibiotic, claiming that this has to be the way forward. Money was the most pressing issue because, as everyone at the conference knew, for many years pharmaceutical companies have been pulling back from antibiotics research because they can’t see a profit in it. Development costs run into billions of dollars, yet there is no guarantee that any new drug will successfully fight infections. At the same conference Dr. Lloyd Czaplewski spoke about alternatives to antibiotics, in case we cannot come up with new ones fast enough to outrun superbug evolution. But he omitted mention of preventive strategies that use the internet or communication software to help reduce the spread of infections among families, communities, and countries. It is madness that we don’t have a concrete second-best alternative to new antibiotics, because we need them and we need them quickly. Of course, this is why we have governments, which have been known occasionally in the past as commonwealths. Governments are supposed to look out for the wider, common interests of society that niche-interested professionals take no responsibility for, and that includes public health. It is why nearly every nation’s government has an official who is analogous to the U.S. Surgeon General, and nearly every one has a public health service of some kind. Alas, national governments do not always function as they should. Several years ago physician and former Republican Senator Bill Frist submitted a proposal to the Senate for a U.S. Medical Expeditionary Corps. This would have been a specialized organization that could coordinate and execute rapid responses to global health emergencies such as Ebola. Nothing came of it, because Dr. Frist’s fellow politicians were either too shortsighted or too dimwitted to understand why it was a good idea. Or perhaps they simply realized that they could not benefit politically from supporting it. Plenty of mistakes continue to be made. In 2015, a particularly infectious form of bird flu ripped through 14 U.S. states, leading farmers to preventively slaughter nearly 40 million birds. The result of such callous and unnecessary acts is that, instead of exhausting themselves in the host population of birds, the viruses quickly find alternative hosts in which to survive, and could therefore easily mutate into a form that can infect humans. Earlier, during the 1980s, AIDS garnered more public attention because a handful of rich and famous people were infected, and because the campaign to eradicate it dovetailed with and boosted the political campaign on behalf of homosexual rights. Methicillin resistant Staphylococcus aureus (MRSA) in hospitals, by far the bigger threat at the time, was virtually ignored. Some doctors knew that MRSA would bring us to our knees and kill millions of people worldwide, but pharmaceutical companies and device and equipment manufacturers ignored these doctors and the thousands of patients dying in hospitals as a result of MRSA. They prioritized the wrong thing, and government did not correct the error. And that is partly how antibiotic-resistant infection went from an obscure hospital problem to an incipient global pandemic. Politics well outside the United States plays several other roles in the budding problem that we are confronting. Countries often will not admit they have a problem and request help because of the possible financial implications in terms of investment and travel. Guinea did not declare the Ebola epidemic early on and Chinese leaders, worried about trade and tourism, lied for months in 2002 about the presence of the SARS virus. In 2004, when avian influenza first surfaced in Thailand, officials there displayed a similar reluctance to release information. Hospitals in some countries, including India, are managed and often owned by doctors. They refuse to share information about existing infections and often categorically deny they have a problem. Reporting infections to public health authorities is not mandatory, and so hospitals that fail to say anything are not penalized. Even now, the WHO and the CDC do not have accurate and up-to-date information about the spread of E. coli or other infections, and part of the reason is that for-profit hospitals are reluctant to do anything to diminish their bottom line. Syria and Yemen are among those countries that are so weak and fragmented that they cannot effectively coordinate public healthcare. But their governments are also hostile to external organizations that offer relief. Part of the reason is xenophobia, but part is that this makes the government look bad. Relatedly, most poor-nation governments do not trust the efficacy of international institutions, and think that cooperating with them amounts to a re-importation of imperialism. They would rather their own people suffer and die than ask for needed help. That brings us to the level of international public health governance. Alas, sometimes poor-country governments estimate the efficacy of international institutions accurately. The WHO’s Ebola response in 2014-15 was a disaster. The organization was slow to declare a public health emergency even after public warnings from Médecins Sans Frontières, some of whose doctors had already died on the front line. The outbreak killed more than 28,000 people, far more than would have been the case had it been quickly identified. This isn’t just an issue of bureaucratic incompetence. The WHO is under-resourced for the problems it is meant to solve. Funding comes from voluntary donations, and there is no mechanism by which it can quickly scale up its efforts during an emergency. The result is that its response to the next major disease outbreak is likely to be as inadequate as were its responses to Ebola, H1N1, and SARS. Stakeholders admit that we need another mechanism, and most experts agree that the world needs some kind of emergency response team for dangerous diseases. But no one knows how to set one up amid the dysfunctional global governance structures that presently exist. Maybe they should turn to Bill Frist, whose basic concept was sound; if the U.S. government will not act, perhaps some other governments will, and use the UN system to do so. But as things stand, we lack a health equivalent of the military reserve. Neither government leaders nor doctors can mobilize a team of experts to contain infections. People who want to volunteer, whether for government or NGO efforts, are not paid and the rules, if any, are sketchy about what we do with them when they return from a mission. Are employers going to take them back? What are the quarantine rules? It is all completely ad hoc, meaning that humanity lacks the tools it needs to protect itself. And note, by the way, the contrast between how governments prepare for facing pandemics and how they prepare for making war. War is not more deadly to the human race than pandemics, but national defense against armed aggression is much better planned for than defense against threats to public health. There is a wealth of rules regarding it, too. Human beings study and plan for war, which kills people both deliberately and accidentally, but they do not invest comparable effort planning for pandemics, which are liable to kill orders of magnitude more people. To the mind of a medical doctor, this is strange. Creating Conditions for Infections to Spread Superbug infections spread for several interlocking reasons. Some are medical-epidemiological. Most of the infections of the past thirty years have started in one place and in one family. As already noted, they spread because many infectious diseases are highly contagious before the onset of symptoms, and because it is difficult to prevent patients who know they are sick from going to hospitals, work, and school, or from traveling further afield. But again, one reason for the problem is political, not medical. Many governments have no strategies in place to prevent pandemics because they are unwilling to tell their people how infections spread. They don’t want to worry people with such talk; it will make them, they fear, unpopular. So governments may have mountains of bureaucracy with great heaps of rules and regulations concerning public health, but they are generally unwilling to trust their own citizens to use common sense on their own behalf. This, too, seems very strange. Until now, no one has come forward to help us develop strategies to educate people how to identify and prevent the spread of infection to their families and communities. The majority of stakeholders have also been oblivious to the use of new technologies to help reduce the spread of these infections. There are some exceptions. In a fun blog post called Preparedness 101: Zombie Apocalypse, the CDC uses the threat of a zombie outbreak as a metaphor to encourage people to prepare for emergencies, including pandemics. It is well meaning and insightful, yet when my colleagues and I try to discuss ways of scaling up the CDC’s example with doctors and nurses, they shut down. Nobody plans for an actual crisis partly because it is too scary and hence paralyzing to think about. But it is also because it is not most health professionals’ job; it is not what they are trained and paid to do. It is always someone else’s job, except that it has turned out to be nobody’s job. Worse, the situation is not static. While we sit paralyzed, superbugs are evolving. Epidemiological models now predict how an algorithmic process of disease spread will move through the modern world. All urban centers around the entire globe can become infected within sixty days because we move around and cross borders much more than our ancestors did, thanks to air travel. A new pandemic could start crossing borders before we even know it exists. A flu-like disease could kill more than 33 million people in 250 days.3

1. http://www.dictionary.com/browse/resolved [↑](#footnote-ref-1)
2. http://www.dictionary.com/browse/affirm [↑](#footnote-ref-2)